MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

04167

Reg. Dist. No. 257

1. PLACE OF DEATH: County: Queen Anne's; City or town: Centreville (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 75 yrs; Hospital, institution, or street address where death occurred:; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State: Md. County: Queen Anne's; City or town: Centreville (If outside city or town limits, write RURAL and give nearest town); Street No. (If rural, give LOCATION); 2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles H. Busteed

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Widowed

8.(b) Name of husband or wife: Mollie G. Busteed

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 31 — 1854

8. AGE: Years	Months	Days	If less than one day
90	5	2	..... hrs. ..... min.

9. Birthplace: Near Centre-Caroline Co-Md (Town, county, and state)

10. Usual occupation: Farming

11. Industry or business:

FATHER — 12. Name: Warren R. Busteed

13. Birthplace: Do not know

MOTHER — 14. Maiden name: Katherine M. Barwick

15. Birthplace: Near Sudlersville Md

18. Informant: Mr J. W. Busteed

Address: 1353 Cuba dale Rd - Philadelphia - Pa

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 5-45 (month) (day) (year)

Cemetery or crematory: Chesterfield

Location: Centreville, Md

18. Funeral director: Barton Bros

Address: Centreville, Md

19. Apr 4 — 1945 (Date rec'd by registrar) Ellen Armstrong Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4-2-45, at 2:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to 4-2 19 45 and that I last saw h[illegible] alive on 4-2 19 45.

Immediate cause of death	DURATION
Pneumonia Lobar	
Meas.	
Due to	
Pneumonia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: H. S. McFarland M. D. or other

Address: Centreville Md Date signed: 4-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

04168

CERTIFICATE OF DEATH

Reg. Diat. No. 251

1. PLACE OF DEATH:

County: Queen Anne

City or town: Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne

City or town: Sudlersville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary L. Chance

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 25 - 1865

8. AGE:

Years	Months	Days	If less than one day
79	6	27	..... hrs. ..... min.

9. Birthplace: Q. A. Co. (Town, county, and state)

10. Usual occupation: ~~Retired~~ Housewife

11. Industry or business

FATHER

12. Name: John E. Chance

13. Birthplace: Q. A. Co.

MOTHER

14. Maiden name: Harriett Phillips

15. Birthplace: Q. A. Co.

16. Informant: Mr. Clar. Chance

Address: Sudlersville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 24-45 (month) (day) (year)

Cemetery or crematory: Sudlersville

Location: Sudlersville, Md

18. Funeral director: Edgar L. Lane

Address: Church Hill

19. April 23 19 45 Edgar L. Lane

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 21 19 45 at 11 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 44 to April 21 19 45

and that I last saw h-- alive on April 20 19 45

Immediate cause of death	DURATION
Pulmonary Hemorrhage	
Virus Pneumonia	
Due to	
Due to Pulmonary Tuberculosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations: —

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: C H Metcalfe M. D. or other

Address: Sudlersville Md Date signed 4/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

STATE OF MARYLAND—CERTIFICATE OF DEATH

04169

1. PLACE OF DEATH

County Queen Anne's Registration Dist. No. 253

Village or City Stevensville No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Louis Laurence Coughlin

(a) Residence: No. 4213 Harford Rd St., Ward. Baltimore

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
M.	White	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Mae Coughlin

6. DATE OF BIRTH (month, day, and year) 10-15-1893

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	5	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Machinist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year) 3-31-45

11. Total time (years) spent in this occupation 35 years

12. BIRTHPLACE (city or town) (State or country) Baltimore

FATHER

13. NAME Joseph Coughlin

14. BIRTHPLACE (city or town) (State or country) Baltimore Mass

MOTHER

15. MAIDEN NAME Julie Lawrence

16. BIRTHPLACE (city or town) (State or country) Baltimore Md

17. INFORMANT Lillie Mae Coughlin (Address) Stevensville Md

18. BURIAL, CREMATION, OR REMOVAL Place Oak Lawn Date April 5, 1945

19. UNDERTAKER John C. Moran (Address) 3000 E Baltimore St

20. FILED April 1, 1945 Frank C. Thomas Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH April (Month) 1 (Day), 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...

I last saw h... aliva on ..., 19...; death is said to hava occurred on the date stated above, at ... m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows: Coronary occlusion — Date of onset 1

No physician in attendance.

Other **Contributory Causes** of importance:

Name of operation ... Date of ...

What test confirmed diagnosis? ... Was there an autopsy?

23. If death was dua to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of injury ..., 19...

Where did injury occur? ... (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury ...

Nature of injury ...

24. Was diseasa or injury in any way relatad to occupation of decaased? No

If so, specify ...

(Signed) Samuel J. Bruce M. D.

(Address) Centreville

If more blanks are needed, address State Registrar, 2411 N. Charles Street Baltimore Requesting U. S. No. 1.

Deputy Medical Examiner.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. A CAUSE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at **school** or at **home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

04170

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Queen Anne's
City or town: Head Millington (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, institution, or street address where death occurred: Palmatory Nursing Home
How long in hospital or institution? 3 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Queen Anne's
City or town: Church Hill (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Dewberry

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed

6.(b) Name of husband or wife: Thomas Dewberry
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 4. 1873

8. AGE: Years	Months	Days	If less than one day
72	0	22	..... hrs. ..... min.

9. Birthplace: Queen Anne's Co. Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
12. Name of father: Thomas Austin
13. Birthplace of father: Talbot Co. Md.
14. Maiden name of mother: Sarah E. Tucker
15. Birthplace of mother: Unknown
16. Informant: Mrs. Martha Richards
Address: Church Hill Md.
17. (Burial, cremation, or removal, Which?) Burial Date thereof April 29-1945 (month) (day) (year)
Cemetery or crematory: Crumpton Cem.
Location: Crumpton Md.
18. Funeral director: Edgar L. Lane
Address: Church Hill Md.
19. (Date rec'd by registrar) April 27 1945 Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 26 1945, at 10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1945, to April 26 1945
and that I last saw alive on April 24 1945

	DURATION
Immediate cause of death: Uremia	4 days
Due to: Hemiplegia	(1941)
Due to: Arteriosclerosis Chr. Interstitial nephritis	1938
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. E. Brinsfield M. D. or other
Address: April 27th Millington Md. Date signed

Dr Price
04171

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 254

1. PLACE OF DEATH:
County: Queen Anne
City or town: Queenstown Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Queen Anne
City or town: Carmichael
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME Hattie R. Griffin

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Charles Griffin
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Sept 13 1885

8. AGE: Years	Months	Days	If less than one day
59	6	29	hrs. min.

9. Birthplace: Carmichael Md (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER 12. Name: Joseph Price
13. Birthplace: Carmichael Md
MOTHER 14. Maiden name: Rebecca Glascoe
15. Birthplace: Carmichael Md
16. Informant: Albert Griffin
Address: Queenstown R D Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr 13 45 (month) (day) (year)
Cemetery or crematory: John Wesley Church
Location: Carmichael Md
18. Funeral director: John D Williams
Address: Easton Md
19. 4-13 1945 H. M. Aldridge Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 11 1945, at 12:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1 1945 to April 11 1945
and that I last saw her alive on March 31 1945

Immediate cause of death	DURATION
Exophthalmic Goitre	5 Yrs
Due to: Pyper-thyroidism	
Due to:	
Other conditions: Mitral regurgitation, arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Samuel I Price M.D.
M. D. or other
Address: Queenstown Date signed 4-12-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04172

Reg. Dist. No. 251

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Queen Anne's

City or town: Church Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Church Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Julia M. Payne

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed

6.(b) Name of husband or wife: Bowers Payne

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24 - 1863

8. AGE: Years	Months	Days	If less than one day
82	1	10	..... hrs. ..... min.

9. Birthplace: Queen Anne Co. Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: Geo. R. Hollingsworth

FATHER 13. Birthplace: Queen Anne Co. Md.

MOTHER 14. Maiden name: Ellen Birch

MOTHER 15. Birthplace: Queen Anne Co. Md.

16. Informant: Mrs. Mae Jester

Address: Church Hill Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 5 - 1945 (month) (day) (year)

Cemetery or crematory: Centreville Cem.

Location: Centreville Md.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. April 4 45 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 3 19 45, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 22 19 45 to April 3 19 45

and that I last saw h[illegible] alive on April 3 19 45

Immediate cause of death: Pulmonal Thrombosis — DURATION: 1 day

Due to: Cerebral Hemorrhage — 7 days

Due to: Hypertension — Yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard M. Deadly M.D. or other

Address: Church Hill Date signed: April 3 45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

04173

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Queen Anne's County

City or town: Millington Town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 1/2 weeks

Hospital, institution, or street address where death occurred: Mrs Palmatory's Infirmary

How long in hospital or institution? 4 1/2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Susan Amanda Porter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Oct 2 1864

8. AGE: Years: 80 Months: 5 Days: 7 If less than one day: hrs. min.

9. Birthplace: Kent Co. Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: own

FATHER 12. Name: John Henry Porter

13. Birthplace: Kent Co. Md

MOTHER 14. Maiden name: Rachel McDeett

15. Birthplace: Kent Co. Md.

16. Informant: Mrs George Colliger

Address: Rock Hall, Md

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof APRIL 12, 1945 (month) (day) (year)

Cemetery or crematory: Wesley Chapel Cem.

Location: Near ROCK HALL, Md.

18. Funeral director: J. WILLIS WELLS

Address: CHESTERTOWN, Md.

19. April 10 1945 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 9 1945 at 1:50 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 4 1945, to April 9 1945 and that I last saw h. alive on 3-5 1945

Immediate cause of death	DURATION
fractured L. Hip	
Due to Hypostatic Pneumonia	
Due to Accidental fall — slipped on ice. C.V.D.R.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: January 4, 1945

Where did injury occur? Rock Hall (City or town) Maryland (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Accidental fall. Injured at work?

23. SIGNATURE: Albert A Burgard M. D. or other

Address: Rock Hall, Md Date signed: 4/9/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04174

Reg. Dist. No. 251

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Queen's Anne County
City or town: Sudlersville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Sudlersville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: Bertha Richter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Married.

6.(b) Name of husband or wife: Anthony Richter
6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Feb. 25 1901

8. AGE: Years	Months	Days	If less than one day
44	1	20	hrs. min.

9. Birthplace: Jugoslavia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Joseph Burus
13. Birthplace: Jugoslavia

MOTHER
14. Maiden name: Elizabeth Fer
15. Birthplace: Jugoslavia

16. Informant: Anthony Richter
Address: Sudlersville

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 16-1945 (month) (day) (year)
Cemetery or crematory: Church Hill Cem.
Location: Church Hill Md.

18. Funeral director: Edgar L. Lane
Address: Church Hill Md.

19. April 15 45 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 13 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to April 13 1945 and that I last saw h.. alive on April " 1945

Immediate cause of death	DURATION
Chron. Endo carditis	
chron. hypertentia	
Due to: Dropsy, ascites	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: Howard Burgard M. D. or other
Address: Forkhill, Md Date signed 4/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

04175

Reg. Dist. No. 254

1. PLACE OF DEATH:
County: Queen Anne
City or town: Grasonville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Grasonville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: George Samson

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Louise Griffin Samson
6.(c) If alive, give age: about 56 years

7. Birth date of deceased (mo., day, yr.): April 10 - 1888

8. AGE:

Years	Months	Days	If less than one day
57	0	12	hrs. min.

9. Birthplace: Queen Anne Co. Md.
(Town, county, and state)
10. Usual occupation: Farm Laborer
11. Industry or business

FATHER
12. Name: Don't know
13. Birthplace: Don't know

MOTHER
14. Maiden name: Mary Murray
15. Birthplace: Queen Anne Co Md

16. Informant: Louise Griffin Samson
Address: Grasonville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Apr. 26-45 (month) (day) (year)
Cemetery or crematory: Chesterfield
Location: Centreville Maryland

16. Funeral director: Easton Bros
Address: Centreville Md

19. April 26 1945 (Date rec'd by registrar) H. M. Aldridge Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4 - 24 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar. 12 1945, to 4-24 1945
and that I last saw h[illegible] alive on 4-20 1945

Immediate cause of death	DURATION
Chronic Valvular Disease of the heart.	
Due to	
Pneumonia R. Lobe	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. B. McPherson M. D. or other
Address: Centreville, Md. Date signed: 4-24-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

04176

Reg. Dist. No. 251

1. PLACE OF DEATH:

County: Prince Georges

City or town: Fort Lincoln Twp

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 mo.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Phila

City or town: Philadelphia

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Florence Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife: Single

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1857

8. AGE: Years	Months	Days	If less than one day
87	9	10	..... hrs. ..... min.

9. Birthplace: Phila., Pa. (Town, county, and state)

10. Usual occupation: Retired Merchant Buyer

11. Industry or business

FATHER — 12. Name: Zachariah Taylor

FATHER — 13. Birthplace: British W. Indies

MOTHER — 14. Maiden name: Letitia Dark

MOTHER — 15. Birthplace: Phila Pa.

16. Informant: Mrs Temperance Taquette

Address: Fort Lincoln Twp

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 18-1945 (month) (day) (year)

Cemetery or crematory: Woodland Cem.

Location: Phila., Pa.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. April 15 1945 (Date rec'd by registrar) Edgar L. Lane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 15 1945 at 1130 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 13 1944, to April 13 1945 and that I last saw h— alive on April 14 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	
Due to Chronic Myocarditis	
Due to Ch. Nephritis	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: C H Ufferfalls M. D. (M. D. or other)

Address: Fort Lincoln Twp Date signed 4/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

04177

CERTIFICATE OF DEATH

Reg. Diat. No. 251

1. PLACE OF DEATH:

County: Queen Anne's

City or town: Rural Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: near Centreville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary E. Wilson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	Married

6.(b) Name of husband or wife: George H. Wilson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 18 - 1901

8. AGE:

Years	Months	Days	If less than one day
43	6	20	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Brown

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Eliz. Blake

15. Birthplace: Maryland

16. Informant: Mrs. George Wilson

Address: Centreville R. F. D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: April 11-1945 (month) (day) (year)

Cemetery or crematory: Roesville Cem.

Location: Roesville Md.

18. Funeral director: Edgar L. Lane

Address: Church Hill Md.

19. April 8 19 45 E. L. Lane

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: April 7 TH 19 45 at 0.30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to No Physician in	
Due to attendance 2 years	
or more.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: NO

Date of op.

Autopsy results: NO.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel J. Rice M.D. M. D. or other

Deputy medical examiner

Address: Centreville Date signed 4/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15